3.25 PERSONAL CARE ASSISTANCE – STATE PLAN (CONSUMER-DIRECTED MODEL)

INTRODUCTION

Personal Care Assistance Consumer Directed Services (CDS) is a Home and Community Based Services (HCBS) program offered through the Division of Senior and Disability Services (DSDS). CDS is available to participants who can direct their own care and can live independently. CDS participants select an HCBS provider that is enrolled as a CDS provider with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance (MMAC) Unit. Payment is made to the HCBS provider on behalf of the participant. The HCBS provider processes payroll, on behalf of the participant, to the individual providing the services.

Authorization of Personal Care Assistance is funded through both the Consumer-Directed Model Medicaid State Plan and the Independent Living Waiver (ILW). This policy addresses State Plan services only. Refer to the ILW Policy for additional information regarding services through the ILW.

PURPOSE

CDS provides assistance with activities of daily living (ADL) and/or instrumental activities of daily living (IADL) provided as an alternative to nursing facility placement to persons with a physical disability.

ELIGIBILITY

All CDS participants must meet the following eligibility criteria:

- Be at least eighteen (18) years of age
- Be physically disabled, as defined by 19 CSR 15-8.100
  - Loss of, or loss of use of, all or part of the body's neurological, muscular, or skeletal functions to the extent the person requires the assistance of another person to accomplish routine tasks.
- Be able to self-direct their CDS
- In active Medicaid status
  - Participants eligible for Medicaid on a spenddown basis may be authorized to receive CDS during periods when they meet their spenddown liability.
    - During periods when the participant has **not** met their monthly spenddown liability amount, the participant and provider may make a private arrangement for the continued delivery of services. In these instances, the participant is responsible for the cost of services received.
  - Participants who receive Medicaid due to eligibility for Blind Pension (BP) may be authorized for CDS.
  - Participants in a 'Transfer of Property penalty' may be authorized for CDS.
  - Authorization of CDS does **not** meet the requirements for an individual to be eligible for Home and Community Based (HCB) Medicaid.
- Have an appropriate Medicaid Eligibility (ME) Code

- Meet nursing facility level of care (LOC)
- Have not been previously involved in Medicaid fraud

SELF DIRECTION DETERMINATION

A current or potential CDS participant is required to have the ability to direct their care per 208.903.1.(4), RS Mo. Consumer directed is defined as the hiring, training, supervising, and directing of the personal care attendant. Section 208.909.1, RSMo states that current or potential participants must be able to fulfill the following responsibilities:

- Supervise the personal care attendant
- Verify the wages to be paid to the personal care attendant
- Monitor proper Electronic Visit Verification (EVV) usage
- Notify DSDS staff or its designee of any changes affecting the CDS Person-Centered Care Plan (PCCP) or the participant's place of residence
- Report any problems resulting from the quality of services rendered by the personal care attendant to the participant's provider
  - It shall be reported to DSDS staff or its designee if the problem cannot be resolved through the provider.
- Report to DSDS significant changes in participant's health and/or ability to self-direct their care

Documentation shall be provided in the participant's electronic case record if it is determined that a current or potential participant requesting CDS cannot direct their care or fulfill the responsibilities of a CDS participant. Examples of documentation may include, but are not limited to:

- Responses to questions from the current or potential participant during the assessment process that need further clarification. Questions are to be posed to the current or potential participant.
  - If another individual responds on behalf of the current or potential participant, this must be documented in the case notes.
- Completion of the Self Direction Assessment questions
  - If the Self Direction Assessment Questions are utilized, answers to the questions shall be provided as an exhibit if the current or potential participant appeals the decision that they cannot self-direct services.
- Completion of the St. Louis University Mental Status (SLUMS) exam. This may be utilized when there is a concern regarding an individual's ability to self-direct.
  - The instructions to the SLUMS provide background information on the exam, clarifies when the exam shall be utilized, and defines further evaluation which must be pursued.
- Statements or medical records from the current or potential participant's healthcare professional documenting any functional limitations preventing the individual from self-directing
  - The Healthcare Professional Inquiry may be utilized when there are concerns regarding the current or potential participant's ability to self-direct. The response received from the Healthcare Professional Inquiry shall be documented and uploaded to the electronic case record along with other self-direction determination documents if utilized.

If a thorough review of all available information has taken place and the current or potential participant cannot self-direct, Adverse Action procedures shall be followed, and DSDS staff or its designee shall advise that individual and/or the authorized representative of other available options. The Collateral Contacts Policy, outlines the various services available through alternative HCBS. Current or potential participants shall be advised that Personal Care (PC) and Advanced Personal Care (APC) services are comparable to services available through the CDS program.

- DSDS staff or its designee shall document the discussions held regarding the availability of other services.

RESTRICTIONS AND LIMITATIONS

CDS shall **not** be authorized to pay for services when:

- The primary benefit is to a household unit.
- The task is one that household members may reasonably be expected to share or do for one another unless the task is above and beyond typical activities provided for a household member without a disability.
- CDS does not include any task that must be performed/ trained by a licensed professional (i.e., skilled nursing, therapies ordered by a physician, etc.).
- A physically disabled person who can direct their care but has a cognitive impairment that requires a designated person to assist with the administration of the program can only be authorized through the ILW.
- Participants authorized for self-directed services through the Department of Mental Health (DMH) are not eligible for services as outlined in this policy. Staff shall refer to the Service Coordination Policy for guidance on coordinating services for participants authorized for DMH services.
- Individuals who reside in a nursing facility, Residential Care Facility (RCF) or Assisted Living Facility (ALF) licensed by DHSS, Division of Regulation and Licensure (DRL) are not eligible for CDS.
- The 'CDS Restricted' checkbox in the participant's electronic case record has been checked. This box can be checked when:
  - DSDS staff followed the procedures outlined in the Adverse Action policy and Appeal and Hearing Process. Services shall not be closed until the 10-day appeal time frame has passed, and the participant has not appealed, or until the Department of Social Services (DSS), Division of Legal Services (DLS) has made its final decision for the appeal hearing affirming the adverse action.
  - As appropriate, all current authorization(s) for CDS shall be closed, and other HCBS that may meet the participant's needs have been offered to the participant, e.g., Agency Model.
- The attendant shall not:
  - Have been involved in Medicaid fraud previously
  - Be a current CDS participant
- Participants can exercise individual choice in deciding who provides their CDS. The CDS participant is the attendant's employer-of-record.
  - The attendant may be a family member. However, the attendant cannot be the participant's spouse or legal guardian.

NOTE: An individual with a guardian or conservator cannot be rejected for CDS solely for that reason. Explanation for the need of a guardian or conservatorship can justify the reason to reject CDS due to cognitive inabilities to self-direct. DSDS staff or its designee shall obtain a copy of the appointment order.

AUTHORIZATION

The following is an overview of CDS authorizations and tasks:

- CDS shall be authorized in 15-minute units
- CDS shall be included in the overall cost of care for the participant as referenced in the HCBS Cost Maximums policy
- CDS shall not exceed 60% of the cost maximum
  - The combination of CDS and agency model PC shall not exceed 60% of the cost maximum.
- The 60% cost maximum can be exceeded by the cost of APC and RN visits, but only up to the full monthly cost of 100%.

NOTE: When the care plan includes RN services, the cost of one RN visit shall be excluded from the overall care plan cost.

- When the combination of CDS, other State Plan services, and an HCBS Waiver (e.g., Aged and Disabled Waiver (ADW) or ILW) services exceed the cost maximum by the cost of the waiver services:
  - The appropriate supervisor for the DSDS staff shall review all PCCP requests over the 100% cost maximum to ensure the participant's unmet needs require the amount of service requested.
  - If documentation supports the request, the case shall be forwarded to the Bureau of Federal Programs (BFP) for consideration and approval prior to authorization over 100% of the cost maximum.
  - Pending the approval from BFP to exceed the cost maximum, CDS in combination with other State Plan or ADW services can be authorized up to 100% of the cost maximum, excluding PC and/or CDS, which may never exceed 60% of the cost maximum.

NOTE: When a PCCP includes Adult Day Care authorized through the ADW or the Adult Day Care Waiver (ADCW), the total cost of care **cannot** exceed 100% of the cost maximum.

Under federal guidelines, a participant can only enroll in one (1) HCBS Waiver at a time, regardless of what agency administers the waiver program.

TASKS

CDS provides "hands-on" assistance with physical tasks that benefit the participant and are based on the participant's physical limitations. No time can be authorized for the following:

- Stand-by assistance, prompting, or cueing
- Respite care or for time spent waiting for a participant at any appointment

CDS may include any of the following tasks:

- Assistance with Transfer Device
  - Use an assistive device for transfers
- Bathing

  - Direct assistance with bathing and shampooing hair that requires active participation by the aide (e.g., hands-on washing assistance, assistance in or out of the bath, gathering supplies/clean clothing, etc.)
- Bowel/bladder
  - Administration of prescribed bowel programs, including the use of suppositories and sphincter stimulation per protocol and pre-packaged enemas for participants without contraindicating rectal or intestinal conditions
- Catheter hygiene:
  - Changing bags and soap and water hygiene around the site of external, indwelling, and suprapubic catheters.
  - Removal of external catheters, inspect skin, and reapply catheter
- Change linens
- Clean bath
- Clean floors
- Clean kitchen
- Cleaning/maintaining equipment
  - Wheelchairs, bedside commodes, shower chairs and nebulizer machines, etc
- Dressing/grooming:
  - Direct assistance with dressing and undressing, combing hair, nail care, oral hygiene, shaving, and assisting with prosthetics
- Essential correspondence
- Essential transportation, including all essential shopping/errands (regardless if the participant is with the CDS attendant), medical appointments, school, or employment, etc.
  - For the participant to be eligible for transportation assistance, there must also be an identified need for personal care assistance, even if that need is met by supports other than CDS.
  - CDS Transportation does **not** include transporting to medical appointments when that appointment is covered under the Non-Emergency Medical Transportation (NEMT) program. To determine if NEMT covers the medical appointment, contact the NEMT provider at 1-866-269-5927.
- Laundry (home)
- Laundry (off-site)
- Make bed
- Meal prep/eating
  - Direct assistance with meal preparation, feeding and clean up.
- Medications
  - Direct assistance with medications (e.g., the time spent handling the medication container, including inhalers, medication for nebulizers, ointments/lotions, steadying the participant's hand/arm to get oral medication and inhalants to mouth, and water to the participant)
- Mobility/transfer

  - Direct assistance with mobility, transfer, and ambulation when the participant can at least partially bear their weight
- Ostomy hygiene
  - Changing bags and soap and water hygiene around an ostomy site (including tracheostomies, gastrostomies, and colostomies, all with a well-healed stoma)
- Passive Range of Motion
  - Passive range of motion (non-resistive flexion of joint within normal range) delivered in accordance with the care plan
- Tidy and Dust
- Toileting
  - Direct assistance with toileting tasks. This may include assistance using or transferring to/from the toilet, commode, bedpan, urinal, cleansing after use and assistance with incontinence episode(s). (The suggested time is 5 minutes multiplied by the number of times assistance is given per day based upon the suggested frequency needed)
- Trash
- Treatments
  - Eye drops, rubbing creams or lotions that are prescribed or non-prescribed
- Turning/positioning
- Wash dishes

CALCULATING ESSENTIAL TRANSPORTATION

Essential transportation is entered on the care plan as minutes per month. To calculate essential transportation, the total number of minutes needed per day is multiplied by the number of days per month. Utilize the chart below to determine the number of days per month based on the frequency per week.

# of Days/Week	1	2	3	4	5	6	7
# Days/Month	*5	10	15	19	23	27	31

Calculation Formula: number of minutes per day x number of days per month = number of minutes per month

NOTE: To account for months with 5 weeks, the formula always calculates based on a five-week month.

The total number of minutes should be entered on the care plan.

Example: 90 minutes, once a week: 90 x 5 = 450 minutes

Example: 60 minutes, twice a week: 60 x 10 = 600 minutes

Example: 60 minutes, three times a week: 60 x 15 = 900 minutes

Example: If there is an unexpected outing, such as a medical appointment not covered by NEMT, the additional time for the appointment should be calculated and added to the current authorization for essential transportation.